DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE 395379			A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 04/26/2023	ΞY	
NAME OF PROVIDER OR SUPPLIER: WECARE AT LOYALSOCK REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 1445 SYCAMORE ROAD MONTOURSVILLE, PA 17754				
	SE NUMBER: 194402			- 1			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0000	Findings of an Abbreviated Survey to review two Complaints completed on April 26, 2023, at Wecare At Loyalsock Rehabilitation And Nursing Center identified no deficient practice, related to the reported complaint allegations, under the requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.		F 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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Certified End Page

WECARE AT LOYALSOCK REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 194402 SURVEY EXIT DATE: 04/26/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY